Healthcare Re-Visited (Again)

As we mentioned in our September and October 2018 newsletters, Socialism doesn't work. It never has, and it never will. Here are some important facts regarding Obamacare that the Left doesn't want you to know. The number of uninsured citizens prior to Obamacare was approximately 45 million. Interestingly, this percentage of citizens is similar to the overall level of poverty in our country - - approximately 14% (although these groups of citizens do not overlap exactly). This poverty rate hasn't changed very much since the 1960s, despite the massive amount of money spent by government on welfare programs and other "cures" for poverty. The current number of uninsured citizens is now down to "only" approximately 28 million. However, nearly all of this decrease over the past eight years is due to people who have been added to the various states' Medicaid rolls. Granted, there has been a small number of citizens who did obtain health insurance policies via the HealthCare.gov website (with the benefit of tax-payer subsidized premium assistance) but the actual number of sign-ups has been significantly less than the numbers originally projected. Simply put, the Obamacare "entitlement" has been totally ineffective and has led to a large increase in dependency on the federal government. (But maybe that was the Left's goal all along).

The Democrats' success in the 2018 midterm elections in becoming the majority party in the US House of Representatives was primarily due to one single issue - - "pre-existing conditions". Our Editorial Board has read the US Constitution and has not found a single reference to any requirement of the federal government to deal with healthcare issues, or to "solve" any particular individual's pre-existing condition.

Of course, many Socialists will claim that the federal government's meddling in our country's healthcare system is covered by "the General Welfare clause". However, under that theory, there is absolutely no limitation on the size and scope of the federal government. (The limitation on the size and scope of the federal government was the purpose of the Tenth Amendment).

We find it interesting that the issues that seem to be the most vexing to our country's citizens (and where many people struggle financially) are those aspects of life where the federal government has intruded into the marketplace. This includes the cost of college education and the resulting explosion of student loan debt (which now needs to be "forgiven"). It also includes the cost of housing - - Freddie Mac and Fannie May should be privatized, and the federal government should get out of the mortgage loan business. And now, the federal government has befouled our country's healthcare system. Obamacare has been an abject failure, and our country should not "double-down" on the next bad (worse) idea that is being proposed by the Left - "Medicare for All". The one "bright spot" (where the federal government hasn't overly tainted the economics) is our country's agriculture industry and the country's food supply. However, the Washington DC bureaucrats continue to meddle in agriculture, too.

In ***The 2020 Initiative***, we recommend the establishment of four "pass-through" national charities for food, education, housing and healthcare. These charities would be funded with private citizens' donations, which would allow those taxpayers to receive a 100% tax credit against a portion of their federal income tax obligation. Each of these aspects of life represent a Personal Responsibility (not a "right"), and the federal government should not try to administer (intrude upon) these aspects of life, which are more effectively dealt with by private enterprises and Civil Society organizations.

The simple fact of the matter is…. You cannot cure poverty with taxpayer-provided funds. Additional "entitlement" programs simply lead to more dependency. As we have mentioned elsewhere on our website, the best solution to ending poverty is to help the poor become "unpoor". The federal government's "solution" (providing welfare funds) does not solve the issue of poverty, and the Left's approach ends up being counter-productive. The best economic system that has ever been devised to create wealth for a country and its citizens is the Free Market and capitalism (not Big Government / Socialism). This fact has been borne out by history and by any objective assessment of the current state of affairs in various countries around the world. Unfortunately, the United States is now ranked only 17th out of 162 countries in the 2018 Human Freedom Index published by the Fraser Institute, the Cato Institute, and the Friedrich Naumann Foundation for Freedom. Russia was ranked number 119, China was 135, and Venezuela was 161.

The Socialists of the Left are trying to sell "Medicare for All" on the false hope that our country's healthcare system would be so much better if we relied upon the expertise of the federal government. And our country's healthcare costs would go down if we were to implement a single-payer, socialist system. We highly doubt this premise. (OK…. We couldn't disagree more). The fact of the matter is there are only two ways to lower an individual's / family's health insurance premium. The Socialists' standard solution (which applies to any economic issue) is simply to have someone else pay for the cost. Yes, it is true this approach would serve to lower that individual's / family's cost, but this approach does nothing to actually lower the overall healthcare bill for the country as a whole. It simply shifts the costs away from someone (who is now getting something "more affordable" or "free") to another individual / family who ends up paying not only their own cost, but the additional cost for someone else as well.

The other alternative is to let the Free Market and capitalism lower the country's overall healthcare costs by re-introducing consumer choice and provider competition into the marketplace. But unfortunately, we are facing a steep uphill climb, due to the past sins of the federal government and its history of distorting the healthcare marketplace.

Let's start with 1954, when the federal government made its first major blunder (that continues to distort the health insurance marketplace today). Prior to World War II, few citizens had health insurance. And if they did have insurance, most policies covered only hospital costs and ancillary services. In order to get around the wage controls instituted by the National War Labor Board, many employers began to offer group health insurance plans. That, in itself, was OK. Our Editorial Board has no problems with group health insurance plans. In fact, as we discuss below, this is one of the better solutions to help address the issue of pre-existing conditions.

However, the federal government oftentimes violates the concept of "Favoritism to None", and it created a marketplace distortion in the Revenue Act of 1954. This law included a provision whereby the cost of an employer's contribution to a group health insurance plan was excluded in determining an employee's taxable income. Interestingly, this is probably the only instance within the entire US tax code where one party (the employer) can take a tax deduction, and the related counterparty (the employee) does not need to report the income. This group health insurance exclusion is one of the largest "tax preference" items in the entire tax code. The cost of this "tax preference" is estimated to be approximately $275 billion per year in foregone tax revenue. Eliminating this tax preference would go a long way towards solving the federal government's annual deficit. Plus, it levels the playing field between those citizens who have the good fortune of working for a company that offers

a group health insurance plan, versus someone who needs to shop for an individual health insurance policy in the (distorted) marketplace.

One other "unintended consequence" that was caused by this change in the tax code is that employees have never truly understood the cost of this group health insurance benefit, and so they experience "sticker shock" when they go out and try to obtain a policy of their own in the individual health insurance marketplace.

Fast forward to 2010, when the Democrats in Congress further intruded into the marketplace by passing the (Un)Affordable Care Act. It should be noted that many of the "experts" who assisted in drafting the Obamacare legislation were health insurance company executives. And what was the end result of this exercise in crony capitalism /crony socialism? Between 2013 and 2017, premiums for individual health insurance policies in twenty-four states more than doubled. And in three states, premiums more than tripled. Similarly, the costs for group health insurance plans also skyrocketed, primarily due to the coercive "employer mandates" embedded in this disastrous legislation.

There are several other "inconvenient truths" about Obamacare that the Left does not want you to know. Besides the adverse effects on premium costs, there has also been a significant decrease in the availability of competing healthcare plans in the marketplace. In over 80% of the counties across the country, consumers now have a "choice" of only one or two plans. In addition, for the millions of people who have been added to the Medicaid rolls over the past several years, the supply of healthcare providers has been decreasing, because many providers are no longer taking new Medicaid patients.

But the real costs of socialized medicine are as follows - - the quality of care declines, there is a lack of doctors and an increase in "wait times", which eventually results in the rationing of care. Also, please keep in mind that the proponents of Medicare-for-All want to turn over the administration of our country's entire healthcare system to the same entity (the federal government) that cannot provide reliable, adequate or effective medical care to our country's veterans. The federal government is simply ill-equipped to do anything other than its core responsibilities that are specified in the Constitution.

The Solution(s)

"Mandates" are coercion - - the government defines, and then enforces, the rules. Our conclusion is that a "one size fits all" solution doesn't work for health insurance. The beauty of the Free Market is that insurance companies and healthcare providers need to compete in order to earn consumers' hard-earned dollars. If they fail to deliver, they go out of business. Re-introducing competition into the marketplace is the single most effective way to decrease the country's overall healthcare bill. "Mandates" and other intrusions into the marketplace are counter-productive and drive up costs.

Health Savings Accounts should be available for all individuals / families. Individual consumers are in the best position to make their own best choices on how they want to spend their own healthcare dollars. As we noted in our earlier Conversation Piece, HSAs provide a triple benefit. The income that you contribute into your HSA is excluded from your taxable income. Any investment income that is earned on your HSA balance is also excluded from your taxable income. And (contrary to an IRA or a 401K plan) when funds are withdrawn from your HSA to pay for qualified medical expenses, these withdrawals are also excluded from your taxable income. There is no "use it or lose

it" provision for an HSA, and money in an HSA can be passed on to a surviving spouse or to your heirs. Because HSAs put consumers directly in charge of their own healthcare purchases, they have an incentive to spend their dollars wisely. Congress finally got one thing right - - it created a vehicle that would help individuals / families take personal responsibility for their own healthcare expenses. We recommend that the dollar limitation on the amount of funds that can be set aside in an HSA each year be increased, and that individuals/ families be able to use HSA funds to purchase a personally-owned, portable, high deductible insurance policy.

It should be noted that one other consequence of low-deductible group health insurance policies is that many people now tend to view health insurance as being "a pre-paid service". In its truest sense, an insurance policy is an actuarial-based product that is used to mitigate risk. We don't buy insurance for everything. But many people have come to view health insurance as "it's a free benefit, so I'll use as much of it as I want" - - hence, our country's large annual healthcare cost. When we buy "insurance" for an annual physical exam or a monthly cholesterol prescription, we are really prepaying for a known expense, and we aren't really buying insurance.

On the other hand, a high-deductible policy (catastrophic insurance) is a way to mitigate the risk and cost of an "unknowable event". A high-deductible, event-based health insurance system will result in lower prices, better patient control over healthcare choices, more transparency of prices, better access to medical professionals, wiser shoppers, lower administrative expenses, and a lower annual healthcare bill for our country as a whole.

Another key aspect of health insurance is that once an individual / family has acquired a health insurance policy, and continuous coverage has been maintained, an individual / family should be shielded from any potential loss of coverage due to a "change in conditions". This is one of the few "mandates" that should be retained.

So that leaves us with the questions about "pre-existing conditions". Let's start with a young adult with a pre-existing condition, who needs to roll off his/her parents' health insurance policy. If continuous coverage had been maintained by his/her parents, this individual should not be penalized in the marketplace by that insurance company when they go to acquire their own insurance policy.

So, what happens if you have a pre-existing condition and you haven't maintained continuous coverage - - how do you get back into the health insurance market? The "easiest" way would be to find an employer who can get you covered under the company's group health insurance program. Once coverage has been established and then continuously maintained, you should be able to subsequently move to an individually-owned insurance policy in the event such a change in coverage would need to occur in the future.

The most important element in all of the above recommendations is to set aside as much money as possible in a personally-owned HSA to cover the cost of health insurance premiums and other healthcare costs.

So, that leaves us with the question of what can be done for low-income individuals / families who find it difficult to afford a health insurance policy, or who have a pre-existing condition, and have difficulty in obtaining an affordable health insurance policy. As mentioned above, there is always going to be a certain number of people who are going to need assistance / welfare. There are several

different ways that these individuals' needs can be addressed. The Socialists' response immediately becomes "Well, that's the reason why we need Medicare-for-All." One pundit described that approach as using a chainsaw instead of a scalpel to address the issue of pre-existing conditions.

Unfortunately, the Left doesn't want you to know the price tag for their Medicare-for-All solution. Currently, the payroll taxes that are deducted from our citizens' paychecks for medical care taxes total approximately $300 billion per year (out of total federal tax receipts for all types of taxes of $3.4 trillion). Two separate organizations – the liberal Urban Institute and the conservative Mercatus Center at George Mason University – both independently estimated the 10-year costs of Medicare-for-All at approximately $32 trillion - - an average of $3.2 trillion per, which is only slightly less than the total amount of tax dollars the federal government is currently collects each year.

The Democratic party used a very effective lie in misleading the public during the 2018 midterm elections - - "The GOP is trying to take away our healthcare". Healthcare is not the same thing as a health insurance policy. People can still get healthcare, even if they don't have health insurance, or if they haven't yet met the deductible on their health insurance policy. Plus, the lie couldn't be further from the truth, because the GOP bill was simply a different approach and an attempt to make the cost of health insurance policies more affordable for everyone. (But wait a minute…. Isn't that what Obamacare was supposed to do??? Oops – that didn't happen). It is true that the proposed legislation (which was passed by the House, but which did not pass the Senate) was going to repeal the various coercive "mandates" that were included in the Obamacare legislation, including all of the "essential health-benefit requirements". However, the Left's "party-line narrative" during the midterm elections failed to disclose the fact that the GOP bill included an alternative approach - - the "replacement" provision that addressed pre-existing conditions.

The Obamacare mandate (coercion) regarding guaranteed coverage was forced upon the health insurance marketplace by the Democrats, along with other rules / parameters regarding how the insurance companies could calculate the amount of premiums they could charge. This simply caused the insurance companies to alter their own regular actuarially-driven processes to determine health insurance premiums. Normally, when an actuary assesses risk, they assign a higher premium when necessary (i.e., someone who has a bad driving record typically pays more for car insurance).

Because of the Obamacare mandates (the distortions) the insurance companies were forced to increase the health insurance premiums for ALL consumers. This was the Socialists' approach towards solving the problems of those individuals who had a pre-existing condition - - they were now going to be able to acquire "more affordable" health insurance (albeit with tax-payer provided premium assistance). The resulting "increased premiums for everyone" was a typical end result of any Socialist-inspired "solution". Also, the numbers of such new policy holders did not materialize as anticipated, and the federal government's meddling in the healthcare industry caused the additional problems in the marketplace noted above.

The fact of the matter was, the GOP-proposed legislation was an attempt to reduce the federal government's role in our country's healthcare system, and to "de-centralize" healthcare back to the states. A key feature of the GOP legislation was federal government "block grant" funds that would be provided to the states to assist those individuals who have "affordability" issues, either due to their level of income, or due to a pre-existing condition. Yes, the Democratic party used a very effective "half-truth" during the midterm elections - - The GOP was going to continue to attempt to repeal Obamacare's coercive (distortive) mandates. But the GOP approach also included a better

plan to deal with the issue of pre-existing conditions by replacing the mandate with block grant funds to the states. And what was it going to cost the federal government to provide those block grant funds to the states? Roughly $25-30 billion per year.

So, let's do some simple math. Would you like our federal government to spend $3.2 trillion each year or $30 billion? (Hence, the reference to a chainsaw versus a scalpel). Forrest Gump's mom would sum this all up by reminding us that "Stupid is as Stupid does."

And here is one last thought about how we can eliminate the federal government's meddling in the healthcare marketplace - - the focus of our country's healthcare system needs to transition back to patients (for choice), their healthcare providers and the Free Market for health insurance policies (for competition and lower costs), and Civil Society (for assistance). In ***The 2020 Initiative***, we recommend that a national Not for Profit "pass-through charity" be established for healthcare donations. The sole purpose of that charity would be to collect funds from citizens, and then (based on stringent, objective criteria that quantifies each state's need regarding its citizens who need financial assistance or who have pre-existing conditions) disburse those funds to the applicable state-level organization in each state. We also recommend that a state's citizens' payroll tax withholdings for healthcare be immediately remitted back to that same state-level healthcare organization. Any additional funding that a state might need would be provided via federal government block grant funds (similar to the approach that was outlined in the GOP-proposed legislation). Who knows – maybe some state can figure this all out, and provide a better road map for other states to follow.

Our Editorial Board has much more faith and confidence in local Civil Society organizations to care for our country's citizens who need assistance, rather than a distant, out of touch, bureaucratic federal government. It will be up to the states and local community Not for Profit organizations to efficiently manage the use of these funds and effectively deliver healthcare services to those individuals / families who need assistance (including those individuals with a pre-existing condition). Nurse practitioners and physician assistants are capable of providing many of the services that are needed by citizens who would be covered by the "public" healthcare option. The other 85% of our country's citizens should be free to obtain their health insurance policies and arrange for their healthcare services in the Free Market.

January 2019